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ABSTRACT

This study, which collected data through interviews and document review, was designed to identify strengths and weaknesses of Minnesota's Comprehensive Children's Mental Health Act (CCMHA) of 1989 and its implementation through December 1990. Three criteria for mental health reform were established for the study, including: care should be community-based and family-centered; a full range of affordable, coordinated services should be provided; and accountability to processes, outcomes, and consumers should be required. Implementation efforts were assessed relative to the three criteria and in terms of administrative support, funding, and bargaining processes. The study concluded that the strengths of the CCMHA lie in its intended commitment to the community-based value, to a fairly comprehensive range of services, to coordination of services at the state and local level, and to process accountability regarding deadlines for implementation and various reports. The weaknesses of the law's intent center on weak or lukewarm commitment to the value of family-centeredness, to informal services such as respite care, to outcome and consumer accountability, and to affordability through financing schemes. Appendixes list documents reviewed, interview questions, and persons interviewed. (Approximately 30 references) (JDD)

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Report on Children's Mental Health Reform in Minnesota

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Introduction

There is a growing consensus regarding the urgent need to reform the system of care for children with serious emotional, behavioral, and mental disorders (Inouye, 1988; Looney, 1983; Saxe, Cross, & Silverman, 1988). The current system emphasizes costly and restrictive inpatient care (Petr & Spano, 1990; Weithorn, 1988) lacks coordination and collaboration among various service providers (Knitzer, 1982), and fails to center its efforts on respectful engagement, involvement, and empowerment of the family (Collins & Collins, 1990). Spurred by the Children's Defense Fund's indictment of the system (Knitzer, 1982), the federal government initiated the Children and Adolescent Service System Program (CASSP), a modest effort to strengthen state departments of mental health and improve networking and coordination in the service delivery system. Meanwhile, at the state level, parent advocates, legislators, and professionals have pushed for reform.

The state of Minnesota has recently initiated comprehensive, legislative child mental health reform. Minnesota passed the Comprehensive Mental Health Act of 1987, a bill that reformed the mental health system for persons with mental illness. Then, because the law did not specifically or comprehensively address the needs of children with emotional, behavioral, and mental disorders, state task forces were formed to draft legislation for children's mental health. These efforts resulted in passage of the Minnesota Comprehensive Children's Mental Health Act (CCMHA) of 1989.

The study reported here was designed to identify strengths and weaknesses of the CCMHA and its early implementation (through December, 1990). As other states begin the reform process, it is hoped that they can learn from Minnesota's experience, adopting successful aspects of the law and overcoming identified barriers to successful implementation.

The reader should note that this study is part of a larger research effort focusing on permanency planning and reasonable efforts for children with disabilities (emotional disorders, developmental disabilities, and medical fragility) in Minnesota. Under the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272), states are required make "reasonable efforts" to maintain abused, neglected, and high-risk children in their families, preventing out-of-home placement if possible. With respect to children with emotional disorders, there is considerable overlap between the mental health and child welfare systems. In general, mental health reform and permanency planning efforts for children both seek to provide community-based service options in the least restrictive environment, maintaining placement in the family if at all possible. Children with emotional disorders can come to the attention of child welfare systems because of the child's "incorrigible" behavior, because the parents are overly stressed and at risk for abusive behavior, or because parents voluntarily relinquish custody so that the state will pay for expensive services that parents cannot afford. Thus, while this study of mental health reform is focused on the implementation of a specific state law, we also considered that its implementation is influenced by other laws, policies, and systems.

After presenting the methods and results of this study, the paper concludes with a discussion of implications and lessons for other states.

Methodology

Conceptual Framework

The methodology for this study relied heavily on an integrated and consumer-focused conceptual framework for implementation studies (Petr, in press; Scheirer, 1981). A key concept in this framework is that the

implementation of any policy and reform must be assessed according to a set of standards or criteria that reflect the goals and potential effects of the reform efforts, especially as these relate to consumers. These criteria thus represent an admittedly "ideal" framework for change. For our specific study, these criteria were established through review of literature on children's mental health reform, and what we know about the consumer perspective (Petr & Barney, in press). Although these criteria may not be exhaustive of all the reform issues, we defend them as representing some of the most major issues on today's reform agenda. While space limitations prohibit an in-depth elaboration of each of these criteria, the reader is referred to the citations for a more complete critique of the current system of care and the rationale for needed change.

Three criteria for mental health reform were established for this study. Although they are presented as distinct criteria, considerable overlap and interconnections between these criteria exist, as will be apparent in later discussion of results and recommendations.

1. Values. There is consensus in the literature that mental health reform must embrace certain values and principles. Programs and services must reflect a larger philosophy that guides their purposes. Chief among these are that programs should be community-based and family-centered (Stroul & Goldman, 1990).

Despite years of reform efforts, the system of care is, at best, ambivalent about the role of inpatient, institutional care (Petr & Spano, 1990). Statistics confirm that children with emotional disorders are being hospitalized, especially in private facilities, at alarmingly increasing rates (Weithorn, 1988). The principle of services in the least restrictive environment, together with knowledge from available research on effectiveness

of interventions (Saxe, et al., 1990) strongly support a move away from institutionally based to community-based services, with the locus of services as well as decisionmaking authority at the community level (Stroul & Goldman, 1990). In addition, the philosophy entails going beyond traditional in-the-office outpatient services, so that mental health services reach children and families where they live and interact in the community. As the Ventura model states, "All mental health services and programs are blended into the structure and procedures of the relevant agencies" (Jordan & Hernandez, 1990, p. 40).

Parents of children with emotional disabilities often are blamed for their children's problems and excluded from treatment decisions (Petr & Barney, in press). Frustrated by their treatment from professionals and the rigidity of systems, parents have organized self-help and advocacy groups, including the nationwide Federation of Families for Children's Mental Health (Collins & Collins, 1990). The value of family centeredness includes the principle of family empowerment and participation in all aspects of assessment and treatment planning (Freisen & Koroloff, 1990).

2. Services. Clearly child mental health reform must include a full range of services for the child and family. A thoroughly comprehensive system of care includes a range of services spanning seven major areas: mental and physical health and social, educational, vocational, recreational, and operational areas (Stroul & Friedman, 1986). In addition, the services must be coordinated among various agencies and service providers, and affordable to the families.

3. Accountability. Accountability is a complex notion, one that can mean different things to different people. Yet it is generally accurate to say that "what gets measured, gets done" (Peters & Waterman, 1982; Rapp &

Poertner, in press). For this study, we identified three aspects of accountability for scrutiny. First is the notion of process accountability, which focuses on procedures and processes that are intermediary steps toward a final goal. For example, in the child welfare field, workers are accountable to write permanency plans for children in care. The plans themselves may or may not result in the final goal of permanency, but are deemed an essential, intermediary step, or a means to an end. Thus, social services are not an end in themselves, but a means to achieving some desired end with clients. Measuring outcome, or whether or not the goal, such as permanency, was actually achieved, is the second aspect of accountability. Accountability to outcome involves performance evaluation relative to specific goals, and is less common in the human services than process accountability. Outcomes are more difficult to define politically, but not necessarily more difficult to measure technically (McDonald, et al., 1989). Finally, accountability to consumers, the clients who receive services, is an essential, if often overlooked, aspect of accountability. Professionals and programs have various constituents to whom they are accountable, from funding sources to the community at large, but one could reasonably argue that consumers (clients) themselves, as the recipients of the services, must take priority. .pa

Data collection

Information about the implementation of reform efforts was obtained both from a thorough review of documents and from interviews with key implementation actors. Twenty-eight documents were obtained and reviewed, including the CCMHA law itself, policies and procedures with respect to the law, the Minnesota Community Social Services Act, the Minnesota Permanency Planning Grants to Counties Act, the Family Investment Plan, training materials, and statistical data (see Appendix A for complete list). Persons

involved with implementation at the state and county levels were interviewed, from top-level state mental health officials to county supervisors to lineworkers to consumer advocates. Face-to-face interviews were open-ended and semi-structured, in that interviewees were asked to respond to 20 questions relating to the three criteria described above (see Appendix B for list of questions). These face-to-face interviews were audiotaped for accuracy and later review. Numerous phone interviews were later conducted to clarify points, obtain new information, and follow up on issues (see Appendix C for list of participants). A draft of the final report was submitted to key informants to verify accuracy of factual material.

Data Analysis

Simply defined, implementation is the stage between enactment and outcome (Majone & Wildavsky, 1979). As such, implementation can be understood as the translation of intent into practice. Thus, for each of the three major criteria, we first assessed the strengths and weaknesses relative to (a) the intent of the laws and policies and (b) the actual practice at the point of service delivery. Since our study focused on early implementation issues (preceding mandated deadlines for implementation of new services), we were not necessarily expecting a great deal of implementation at the client service delivery level. Thus, we purposively chose to look at local implementation in Hennepin County, generally regarded as one of the most progressive counties in the state and thus one of the counties in which implementation could be expected to be the most advanced.

The second aspect of the data analysis was to explain these strengths and weaknesses. As Scheirer and Rezmovic (1983) point out, a complete study of implementation must distinguish between the degree of implementation and the processes of implementation. "Implementation processes are the sequences of

organizational changes and support mechanisms that account for the degree of implementation found at a given time" (p. 601). The strengths and weaknesses regarding each criteria represent the degree to which the reforms have been implemented. To understand and explain these strengths and weaknesses, we asked interviewees questions about the processes and barriers which affected the level of intent and the translation of intent into practice. While these organizational translation processes are extremely complex, previous research (Petr, in press) supports focusing on (a) top-level administrative support for the policy, (b) adequacy of funding to carry out the policy, and (c) bargaining processes among various actors, groups, and affected constituents.

When reporting the results by each criteria, the discussion will first focus on the intent dimension of implementation, then report to what extent the intent has been translated into practice, and finally discuss the processes and barriers that are affecting the level of implementation for that criteria. Before reporting the results, a brief overview of the law and the implementation system in Minnesota is presented.

Overview of Minnesota Law and Implementation Structure

The Comprehensive Children's Mental Health Act (CCMHA) charges the Commissioner of Human Services to "create and ensure a unified, accountable, comprehensive children's mental health system" (245.487, Subd. 3), with full implementation by January 1, 1992 (245.487, Subd. 4). Separate sections of the Act address definitions of terms, planning, coordination, duties of the County board, local service delivery system, quality of services, education and preventive services, early identification and intervention, emergency services, outpatient services, case management and family community support services, residential treatment services, acute care hospital inpatient

services, screening for inpatient and residential treatment, appeals, and children's section of local mental health proposal [245.4871-245.4887]. All children with an "emotional disturbance," defined as any diagnosed organic or clinical disorder (excepting drug or alcohol dependence and mental retardation) that "seriously limits a child's capacity to function" (245.4871, Subd. 15), are to be served by the system. "Severely emotionally disturbed" children are eligible for extra services in the form of case management and family community support services. A diagnostic assessment by a mental health professional is required for designation as "severely" emotionally disturbed (245.4871, Subd. 11).

The formal structure chosen to implement a policy can affect its success or failure (Spano, 1986). Children's mental health reform in Minnesota is to be instituted through the state/county public welfare system. Services in Minnesota are "state supervised and county administered." Twenty states organize their child welfare and/or children's mental health services in similar fashion (Robison, 1990). This form of organization means that policies are established at the state level, first by statute and second by agency regulation, and are implemented by county governments. Each county has a Board of County Commissioners that is responsible to carry out state laws and regulations. These county boards are funded, in part, on a proportional basis by the state, and each county may choose to supplement state funding with additional county dollars. Thus, richer and more socially progressive counties may have better funded service systems than poor, conservative ones, but each must have a minimal system that is approved and monitored by the state. This state supervision is imposed through approval of biennial county social service plans as a condition of funding and through the promulgation of regulations in the form of what Minnesota calls Administrative Rules. A Rule

is a state policy which sets standards for the quality and delivery of services. Rules may pertain both to funding and to programs, and serve to standardize services across all 87 counties.

In the area of children's mental health, policies and programs are established by the CCMHA and the state's Department of Human Services (DHS), Mental Health Division (MHD). Besides the CCMHA, funding for children's mental health services is provided through more than 10 funding programs, with the counties themselves contributing the largest single amount, 45%. The state share for adult mental health services is 57%, but is only 23% of children's mental health (Minnesota, 1991). As of December 1990, case management is the only mandated service for which a Rule is planned. Although it had not been written in 1990 and will not take effect before July 1991, it is expected to address such issues as training, caseloads, funding, and composition of teams. Each Board of County Commissioners is responsible for fulfilling the requirements of CCMHA, and counties are afforded considerable discretion regarding how they organize and deliver services, including the option of contracting with public or private agencies.

The Hennepin County Community Services Department has a complex network of divisions and programs for providing social services. Children with emotional disorders can receive services through the Mental Health Division, the Family Services Division, the Child Protection Division, or the Early Childhood Services Program. The County also has a Developmental Disabilities Division, but children with emotional disabilities are not commonly seen there. The Mental Health Division, as of December 1990, had no lineworkers specifically assigned to work with children, but had hired an Acting Project Coordinator for its Children's Mental Health Project. In late 1990, the

County made the decision to organize and deliver services through a new, administratively autonomous, children's mental health unit.

In Minnesota, Community Mental Health Centers are not necessarily an integral part of county government. They can operate independently as private, non-profit corporations, or the mental health center can be administered directly by the county. Hennepin County has both types of mental health centers. There is a statewide Association of Mental Health Centers, but it was not a key actor in the passage of the CCMHA (though staffs of individual centers were). Mental health centers, individually and collectively, may yet play an important role in children's mental health reform, but that role was not set out in the legislation.

Results

Criterion 1: Values

Community-based. To what extent was the value of "community-based" incorporated in Minnesota's children's mental health reform efforts? The CCMHA law is strong and clear that the main purpose of the CCMHA is to promote better community services. The mission section emphasizes that the proposed mental health system is to "identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs" (245.487, Subd. 3(4)(i)) and provide "mental health services to children and their families in the context in which the children work and live" (245.487, Subd. 3(5)).

The bill's list of mandated services (discussed more fully in the next section) emphasizes community-based care. The first two priorities of implementation (245.4873, Subd. 6) are "the provision of locally available emergency services" and "the provision of locally available mental health

services to all children with severe emotional disturbance." County Boards are required to ensure adequate screening for inpatient and residential treatment that determines whether the proposed treatment is necessary, appropriate, and cannot be effectively provided in the child's home (245.4885, Subd. 1). The CCMHA specifically charges the Department of Human Services to convene a State Task Force on Screening and Residential Treatment Services to determine whether children now served in residential, in-patient settings can be adequately served by out-patient, in-home service (245.4885, Subd. 4).

Although the language of the act strongly supports a community-based philosophy, operationalizing that intent could be another matter. The first State Task Force Report focuses on improving inpatient screening mechanisms, to assure appropriate placements in residential settings. The report states, as many of our informants did, that treatment decisions often appear to be arbitrary, based on cost considerations. Also, some are the result of judges ordering restrictive placements, at county expense, under extreme pressure from parents and against the recommendation of county social services. The report also acknowledges that some children are placed in restrictive settings solely because community services are not available. Yet the report does not go much beyond describing the problems. It fails to recommend a system of screening statewide that would address the problems. Furthermore, neither the CCMHA nor the Task Force Report addresses outcome expectations such as reduction of residential beds, nor does either link the funding and establishment of community programs to a corresponding "deinstitutionalization" of residential beds (Deiker, 1986). On the contrary, the State Mental Health Plan of 1990 anticipates a 2% increase in out-of-home placements for children with emotional disorders, and a 15% increase in

placements in residential treatment centers (Minnesota Department of Human Services, 1990, p. 51).

The barriers to more effective state-level implementation of the strong intent reportedly center on the dimension of bargaining processes. Residential treatment facilities and some professionals have a vested interest in their continuation and prosperity. Another powerful group is local juvenile judges. Through its statewide organization, this group has reportedly opposed any legislation or regulation that threatens the judges' authority to make placement decisions.

At the local level, there is evidence that Hennepin County has endorsed and incorporated a community-based attitude and intent. The County's Mental Health Plan states that placements "that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs" are to be prevented, and "clients receiving Residential Treatment will receive help in acquiring the skills necessary to be referred to outpatient services of a community support program." County staff, who have a strong record of "reasonable efforts" to maintain children in families under child welfare's permanency planning philosophy (AuClaire & Schwartz, 1986), agreed that all available options are to be exhausted prior to recommending residential treatment. Even though the state Division of Mental Health and the aforementioned state task force have failed to decisively devise a statewide screening, or "gatekeeping" system, Hennepin County has reached agreement with local judges that no child will be placed in residential treatment by the court without prior screening by the Children's Mental Health Unit. Funding for the new Children's Mental Health Unit will come, in part, from county funds previously earmarked for out-of-home placements. In addition, the organizing philosophy of the new unit is based on the Ventura model (Jordan

and Hernandez, 1990), which emphasizes out-of-office service delivery in children's homes and schools. So, even though direct services have not yet been delivered under the CCMHA, the county appears well prepared to actualize a community-based philosophy.

Family-centered. With respect to the value of family-centeredness, the CCMHA does not communicate quite the same strong level of intent as it does for the value of community-based. On the positive side, parents and consumer advocates were included on the planning task forces, and the CCMHA does call for establishment of a Local Children's Advisory Council, which must have at least one parent representative (245.4875, Subd. 5). However, in some cases this may mean only one representative, and the act is clear that this council is only advisory to the county board, with no independent responsibility or authority. The Council does not even have to be autonomous or free standing--it can be subsumed as a part of the existing mental health council. The CCMHA statute does specifically call for parental input into mental health treatment plans (245.4871, Subd. 21), similar to permanency planning statutes. However, the Permanency Planning Grants to Counties program explicitly states that its first priority is the preservation of family unity and the prevention of out-of-home placement (Permanency Planning in Minnesota, 1989), whereas the CCMHA makes no such clear statement. Although the CCMHA does not specifically mention the issues of parental blame and stigma, state officials report that these are of great concern to the department, and that reduction of stigma through educational campaigns is one of the major goals of the department.

We found some evidence in Hennepin County that family-centered values may be implemented beyond the specific intent of the law, due in large part to the influence of the Permanency Planning and Social Services Acts. For example, responding to a question about which services were most appropriate for

children with disabilities, a lineworker responded that this depended onwhat was appropriate to a particular family's situation and needs. Another said that the parents needed respite care and this was hard to arrange, demonstrating a sensitivity to what parents themselves report (Petr & Barney, in press). Out-of-home placement of children is considered a last resort, and a worker making such a recommendation must vigorously defend it to two separate teams whose job is to challenge the recommendation before approval. Also, the Local Children's Advisory Committee is active, has 50% representation of parents including the co-chair, and has working subcommittees. Finally, the county conducts surveys of client satisfaction(but divisions vary on how routine these are and on how the information is used).

Conflicts between community-based and family-centered values. One of the barriers to full implementation of these values is their occasional incompatibility, in some people's minds. Direct service providers and supervisors were astute in pointing out that the values of "community-based" and "family-centered" are sometimes in conflict at the service delivery level. Whereas most parents do want to maintain their children in their homes and communities, some parents want and even demand that their children receive care in residential treatment centers, even if they have to give up custody. Thus, workers reported that the local judicial system has sometimes subverted their own efforts to maintain children at home and community by granting parent petitions for placement. Even though lawyers, parents, and professionals attempt to interject the "higher" value of "what's best for the individual child," that judgment is a matter on which well intentioned people can honestly disagree. Some improvement in the tension between these values is reported in Hennepin County, where, as previously mentioned, the local

judge and the Children's Mental Health Unit agreed that the unit would perform a gatekeeping function. Under this arrangement, the court agreed that the unit would be the only entity to perform court-ordered psychological and placement evaluations and the court would not order placement until such an evaluation had been performed.

Criterion 2: Services

Range of services. Despite some notable limitations, we conclude that the bill, overall, indicates a rather strong intent to provide a comprehensive range of services, particularly formal ones, to children and families. The CCMHA requires county boards to use "all available resources" to provide, either directly or through contracts, the following services by the date indicated (245.4875, Subd. 2).

Education and prevention	current
Outpatient services	current
Residential treatment services	current
Acute care hospital inpatient services	current
Early identification and intervention	1/1/91
Emergency services by a mental health practitioner	1/1/91
Professional home-based family treatment	1/1/91
Case management services (new under CCMHA)	7/1/91
Family Community Support Services	7/1/91
Day treatment services	7/1/91
Benefits assistance	7/1/91
Therapeutic support of foster care	1/1/92
Screening for inpatient and residential treatment (by a mental health professional)	1/1/92

This list represents a fairly comprehensive range of services, and includes all of the nonresidential mental health services recommended by Stroul and Freidman (1986). Some recommended residential mental health services, such as therapeutic group care and independent living services, are omitted, but this is understandable given the prioritization of family and community-based care. The list also includes services from Stroul and Freidman's social service category (benefits assistance) and operational services category (case management). Educational, health, vocational, and recreational services are not specified, but other parts of the bill, discussed below, emphasize coordination of these services.

Other important services such as transportation, advocacy, self-help and support groups, and respite care are either omitted or subsumed under the category of family community support services (245.4871, Subd. 17), a service category limited to children with severe disorders. As Friesen and Koroloff (1990) emphasize, omission of these more concrete and informal services could limit effectiveness and sensitivity to family needs. The issue for families is obtaining the resources to meet their needs, but formal services are not necessarily the best resources. The omission of support groups and respite care is particularly glaring, considering that parents find them extremely helpful (Petr & Barney, in press). Respite care is readily available in Minnesota to families with children with developmental delay and to foster parents and is a priority service in child welfare's reasonable efforts to maintain children in their families (Alsop, 1989; Edna McConnell Clark Foundation, 1987). Respite care serves both a preventive function in warding off high levels of stress and a crisis intervention function by providing relief during crisis times (Donner, 1990).

The CCMHA specifies that services are to be provided or contracted by each county, and the law specifies a deadline for implementation of each "new" service not already mandated under other legislation. According to statute, counties do not have the option of determining which services specified in the CCMHA will or will not be offered. However, the CCMHA is considered an extension of the Comprehensive Mental Health Act of 1987, which specifies that nothing in the statute is to be construed as requiring counties to implement services beyond those which can be funded through state appropriations.

Interviewees consistently identified lack of adequate state funding as the major barrier to successful statewide implementation of this range of services. The legislature appropriated only $1.3 million new dollars for implementation, whereas at least one group had sought a minimum of $21 million. The first new funding for services will be awarded in March 1991 (nearly two years after passage of the CCMHA) to counties wishing to establish Family Community Support Services. Because of the inadequacy of state funding, most respondents believe that the state will have to move back its service implementation deadlines, perhaps through 1995 as recommended by DHS (Minnesota, 1991). County administrators are understandably reluctant to begin programs without proper funding. Consumers are understandably frustrated that neither the state nor the counties are appropriating adequate funds. Since counties must have a children's mental health plan approved by DHS to receive funding for any social or health programs, DHS staff will have to determine whether services offered are commensurate with level of funding under CCMHA, other state financing, and county funding.

Some respondents linked the lack of funding to lack of top-level legislative and administrative support for the goals and objectives of the CCMHA. These persons assert that issues for adults with mental illness have

won the political battle within the DHS and its Division of Mental Health (DMH). They point out that from a total of 35 full-time DMH staff, 13 have generic duties, 22 are assigned primarily to adult, and 2.5 are assigned specifically to children's issues. Also, the state share for adult mental health services averages 57%, while the state share for children's mental health services averages only 23% (Minnesota, 1991, p. 13). This lack of commitment to children as a special population was also reported to apply mental health professionals at the local level and was cited as a major barrier to the creation of the separate, autonomous children's mental health unit in Hennepin County.

Also, the DMH is not providing aggressive leadership in developing creative funding such as redistributing dollars from residential and inpatient treatment (Dieker, 1986). State officials reported that even though the state has no initiative in this area, some counties are working on such a redistribution because of its potential cost-effectiveness. Hennepin County is a case in point. As previously mentioned, the county is creating an autonomous children's mental health unit despite lack of state financing under the CCMHA, using a combination of state child welfare, county social services, and redistribution of county out-of-home dollars to accomplish the reorganization. Initially, the efforts will focus on services for those with serious disorders, particularly case management and alternatives to residential treatment. Unfortunately, many other counties have to date provided very limited children's mental health services under any auspices, and say they must rely solely on state CCMHA funding to develop programs.

Coordination. With respect to the issue of coordination, the intent of the bill is strong. At the state level, it mandates that six departments and the district judges' association meet at least quarterly to work on

interagency coordination and financing. Each department is to contribute to an annual report that discusses specific issues in service delivery, financing, and coordination (245.4873, Subd. 2). At the local level, it mandates that each county form Coordinating Councils to assure collaboration and networking. Their responsibilities are to write interagency agreements, collect information about the local system, and write an annual report to DHS, the local county board, and the mental health advisory council (245.4873, Subd. 3). Case management services, which focus in large part on coordination, are one of two services which are required for all children judged to be seriously emotionally disturbed, and it is the only service for which the state plans to promulgate a Rule.

Some aspects of this strong legislative intent have been realized. The state coordinating body has formed and issued its first report, much of which focused on improving local coordination (Mental Health Report, 1990). The report highlighted two major barriers to better coordination. First, agencies lack a clear, shared definition of the target population. Second, compartmentalized and categorical funding streams in multiple agencies fragments service delivery and confuses families. One recommendation was to encourage "co-location" of eligibility determination sites at the local level to facilitate access to services.

The deadlines for the formation of Local Coordination Councils (LCC) was January 1991, and state officials reported that all counties complied. We were unable to ascertain whether any LCC annual reports had been written in 1990. Officials did acknowledge that many LCCs, including Hennepin County's, have been "drifting" because they have received little direction from the state and the legislation is too vague about their precise functions and expectations. Another problematic issue cited by informants is that the Local

Coordinating Councils do not have to be autonomous or free-standing. In many counties, preexisting Child Protection Teams have added members required by the CCMHA and now have dual functions. This situation, together with the absence of a clear role for CMHCs, could indicate that a child protection model, rather than a child mental health one, will guide service delivery. This is reportedly of great concern to parents and advocates, because they believe that endorsement of a child protection model will perpetuate the tendency of professionals to blame parents for children's problems, rather than join with them in mutually respectful collaborative efforts. These considerations were factors in Hennepin County's decision to form an autonomous children's mental health unit.

Affordability. Regarding the last services subcriteria of affordability, the CCMHA clearly recognizes that financing of care is a key issue. The mission statement calls for creation of a system that "addresses the unique problems of paying for mental health services for children" (245.487, Subd. 3(6)). The annual reports from state and local Coordinating Councils are to address the financial issues. Yet the law does not include a special section on this issue, and just how all these new services are to be financed is unclear. So, while the law recognizes the financing issue, it does not attempt to provide a solution, or even the mechanism for devising a solution. Once deemed eligible for services, those services could be paid for from state funds, county allocations, private insurance, state medical assistance, and/or parents. As previously noted, the absence of a clear fiscal plan has been a major barrier to implementation.

Criterion #3: Accountability

Process Accountability. The law requires DHS to make an annual report to the legislature regarding the number of children needing services, the number

who actually received them, and recommendations for further planning and coordination of state agencies providing services. It sets deadlines for the implementation of services, and requires various councils and committees to make annual reports. Thus, the CCMHA focuses its accountability efforts on the process involved in creating a new system. Unfortunately, some of these reports, especially at the county level, have not been written. The service implementation deadlines are all expected to be set back. So, while the law is strong on its intent to hold the system internally accountable, in practice the intents have not been fully realized. The major barrier to timely implementation of service implementation deadlines is reportedly the lack of funding, while the lack of timely reports from local committees can be attributed to failure of state and local officials to aggressively require their completion.

Accountability to outcome and to consumers. While relatively strong in its intent with respect to process accountability, the CCMHA altogether neglects the issues of accountability to outcome and accountability to consumers. No outcomes are specified in the legislation, so it is not possible to hold anyone accountable to them. For instance, one could infer from the legislation that the legislature hopes to see a reduction in out-of-home placements. In contrast to this vagueness, the Ventura model explicitly specified and evaluated six outcome goals, including a goal of 24% reduction in state hospitalizations of minors and achievement of a 68% average reduction over seven years (Jordan and Hernandez, 1990). The CCMHA legislation does call for certain services to be in place by certain dates, but it does not stipulate what the desired outcomes of those services are.

Likewise, the law says little about accountability to consumers, although the requirements for parent input into treatment plans and representation on

Local Children's Advisory Councils can be seen as efforts in that direction. Thus, while the mission statement clearly states the intent to create a "unified, accountable, . . . system," the law leaves the question "accountable to whom, for what?" unanswered.

Still, DHS could use its powers to answer this question if it chooses to do so. DHS must approve county plans before the county is eligible for any state social services monies. This is theoretically a very "big stick," but one which doubters might claim is impractical to use. Yet state supervision of counties in Minnesota has been taken quite seriously--the state is not always just a rubber stamp. This was exemplified recently when DMH delayed state and Title XX funding to Hennepin and 10 other counties for failing to develop adequate plans for case management for adults with severe and persistent mental illness.

Neither is the local level prohibited from developing its own desired outcomes, outcome measures, and accountability to consumers. There is some indication that Hennepin County is going beyond the CCMHA in this latter regard, as exemplified in its client satisfaction surveys, its team review of out-of-home placement recommendations, and its Local Children's Advisory Committee which is autonomous and strongly representative of parents.

Conclusions and Implications

This study has assessed the early implementation of children's mental health reform in Minnesota, as embodied in the Comprehensive Children's Mental Health Act of 1989. The implementation efforts were assessed relative to the strengths and weaknesses relative to three major criteria:

1. the values of community-based and family-centered;
2. the range, coordination, and affordability of services; and

3. process, outcome, and consumer accountability.

The assessed strengths and weaknesses of implementation were then explained and understood in terms of

1. administrative support;
2. funding; and
3. bargaining processes.

Strengths and Weaknesses of the Intent of CCMHA

Overall, the CCMHA is a laudable, yet seriously limited, attempt to reform a troubled system. Relative to the intent of the law with respect to the identified criteria, we conclude that its strengths lie in its intended commitment to the community-based value, to a fairly comprehensive range of services, to coordination of services at the state and local level, and to process accountability regarding deadlines for implementation and various reports. The weaknesses of the law's intent center on weak or lukewarm commitment to the value of family-centeredness, to informal services such as respite care, to outcome and consumer accountability, and to affordability through financing schemes.

Strengths and Weaknesses of County-Level Implementation

In Hennepin County, the strengths include a strong commitment to the community-based philosophy, including its preplacement screening arrangement with the local court, to formation of an autonomous unit to deliver services so that overshadowing by adult mental health or child protection ideologies is minimized, and to creative financing. Some commitment is also evident with respect to the value of family-centeredness and to consumer accountability, and to local interagency service coordination. Overall, we judge that Hennepin has made a strong commitment to children's mental health, especially considering the lack of state financing and state technical support.

Major Barriers to Improved Implementation

The major factors enabling that strong commitment in Hennepin County appear to be the dedication of local top-level administrators, active family advocacy groups, and county taxes that enable the provision of services beyond that funded by the state. Although we did not study other counties in depth, state officials agreed that the situation in most other counties is not as developed. Barriers to optimal implementation statewide include lack of state funding, insufficient staff at the state level, inadequate training of county and professional staff regarding the law and the needs of emotionally disordered children and their families, and the absence of state initiative and leadership regarding funding and statewide screening for inpatient and residential treatment. Additional barriers at the county level include poor tax base, non-autonomous local committees, no history of service to the population, and lack of commitment to the community and family-centered values by professionals and officials.

Implications for Other States

As other states contemplate children's mental health reform, they can benefit from lessons learned in Minnesota. Given that it is desirable for reform to encompass and embrace the criteria of values, services, and accountability outlined in this report, what can reformers do to strengthen their own legislation and its implementation? The implications center chiefly on the implementation processes involved in establishing strong legislative intent and translating that intent into practice: administrative support, funding, and bargaining processes.

In Minnesota, reformers capably organized constituencies and involved key players in the bargaining processes leading to passage of the CCMHA bill. They formed broad-based task forces, developed a mission statement, and

effectively lobbied legislators. Yet, when adequate state funding was not forthcoming, consumers felt betrayed and pressured the counties to carry out the state mandate. But many county administrators resented the state mandating programs that the state would not finance. While most counties floundered, Hennepin County succeeded in implementing the law, even beyond legislative intent relative to some of our criteria. Amidst this turmoil, there are implications for other states regarding the relationship of state and county governments.

First, the Minnesota/Hennepin County experience illustrates how a reform-minded, creative county administration, backed by active consumers, can use state mandates to leverage reform at the local level. Children's mental health reform had been a goal of local Hennepin County administrators for some time, so despite absence of state funding, the County was primed to use the state legislative mandates to overcome local resistance. Thus, a general lesson is that in counties with the administrative support and creativity, with active consumer involvement in political processes, and with a strong local tax base, state legislation can be a key to overcoming resistance in the local bargaining processes arena.

However, for counties that do not have strong local leadership and funding, a stronger state role is necessary to help create and sustain reform. This is where Minnesota's child mental health reform efforts fall short. Consumers in these counties feel betrayed and county administrators resent the state's failure to help them carry out mandates. Reformers in other states can avoid this situation by insisting that no legislation be passed unless funding issues, on both the state and local levels, have been clearly addressed. Since new revenues are so difficult to generate and justify, reformers can consider so-called "revenue neutral" plans (Rapp & Henson, 1987)

that redistribute existing allocations from expensive inpatient to outpatient care. Financing is directly linked to specification of outcomes. Legislation and/or regulations would clearly state the overall goals, specify outcome objectives that are clear reflections of those goals, and articulate the financial mechanisms to achieve the outcomes.

Largely because of the lack of such a financing plan, Minnesota's attempt to implement immediate and statewide reform has been delayed. Because statewide children's mental health reform is such a major and complex task, implementation in other states might be better served by beginning more modestly with strategically located projects so that reform proceeds in phases. This could forestall the problem of consumer discontent and distrust based on overly optimistic expectations, and offer opportunities for fine-tuning policies, programs, and financing.

In Minnesota, children's mental health reform is proceeding through the social services system. Although implementation had not evolved far enough for us to evaluate the relative merits of this organizational structure, some informants were concerned that this system could overemphasize a child protection mindset by service providers. Depending on the way their states are organized, other reformers might choose to organize reform through the mental health system, which would emphasize a medical model and strengthen the role of community mental health centers, or the educational system, particularly special education, which would highlight the educational/ disability approach. The issue of coordination is central to the decision of which is the most appropriate system, because children with severe emotional disorders are found across systems. Because of this, some states may even wish to consider the idea of a local children's authority (Poertner, 1990) in which various categorical funding streams from various systems are pooled at

the local level. As Gair (1988) has pointed out, the needs of children with severe emotional disorders do not differentiate them from all other children. They have the same needs as other children, but differ in the degree and specificity of what must be provided. The local children's authority concept endorses this philosophy and addresses issues of funding, overlap, fragmentation, and community citizen investment in children's welfare.

Finally, reformers in other states, many of whom are parents/consumers frustrated with the system, can learn from Minnesota that a law is not in itself the solution, particularly a law that focuses on service provision as the outcome. Reformers should insist that accountability to outcome and consumers be incorporated, so that the effectiveness of the reforms can be evaluated. Thus, the funding issue must, too, be placed in perspective. Dollars are important, but dollars alone will not make the difference. The dollars must be spent in a context that connects the dollars to the more essential issues of accountability to consumer needs and to overall outcomes. Unfortunately, in Minnesota the controversy and public debate seem to be overly focused on the funding issues. In other states, reformers would be well served to ask first "To whom, and for what outcomes, should the system be accountable?" then "How do we obtain and organize financing to achieve these outcomes?"

References

Alsop, R. (1989). The reasonable efforts requirement in protective services policy. *Protecting Children, 6*(2), 3-6.

AuClaire, P., & Schwartz, I. (1986). *An evaluation of intensive home-based services for adolescents and their families as an alternative to out-of-home placement.* Minneapolis, MN: Hubert H. Humphrey Institute for Public Affairs.

Collins, B., & Collins, T. (1990). Parent-professional relationships in the treatment of seriously emotionally disturbed children and adolescents. *Social Work, 35*, 522-527.

Deiker, T. (1986). How to ensure that the money follows the patient: A strategy for funding community services. *Hospital and Community Psychiatry, 37*, 256-260.

Donner, R. (1990). *Rest a bit: Training for providers of respite care for families of children with emotional problems* (rev. ed.). Topeka, KS.

Edna McConnell Clark Foundation. (1987). *Making reasonable efforts: Steps for keeping families together.* New York: Author.

Friesen, B, J., & Koroloff, N. (1990). Family centered services: Implications for mental health administration and research. *The Journal of Mental Health Administration, 17*(1), 13-25.

Gair, D. (1988). Systems of services for the chronically mentally ill child and adolescent. In J. Looney (Ed.), *Chronic mental illness in children and adolescents* (pp. 213-236). Washington, DC: American Psychiatric Press.

Inouye, D. (1988). Children's mental health issues. *American Psychologist, 43*, 813-816.

Jordan, D., & Hernandez, M. (1990). The Ventura planning model: A proposal for mental health reform. *Journal of Mental Health Administration, 17*(1), 26-47.

Knitzer, J. (1982). *Unclaimed children.* Washington, DC: Children's Defense Fund.

Looney, J. G. (Ed.). (1988). *Chronic mental illness in children and adolescents.* Washington, DC: American Psychiatric Press.

Majone, J., & Wildavsky, A. (1979). Implementation as evolution. In J. L. Pressman & A. Wildavsky (Eds.), *Implementation* (2nd ed.). Berkeley: University of California Press.

McDonald, T., Lieberman, A., Poertner, J., & Hornby, H. (1989). Child welfare standards for success. *Children and Youth Services Review, 11,* 319-330.

Minnesota Department of Human Services. (1989). *Permanency planning in Minnesota.* St. Paul: Author.

Minnesota Department of Human Services. (1990). *Mental health report to the legislature.* St. Paul: Author.Minnesota Department of Human Services. (1991). *Mental health report to the legislature.* St. Paul: Author.

Peters, T., & Waterman, R. (1982). *In search of excellence.* New York: Warner Books.

Petr, C. (1991, in press). A consumer-friendly model of implementation. *Journal of Social Work Administration.*

Petr, C., & Barney, D. (in press). Reasonable efforts for children with disabilities: The parent perspective. *Social Work.*

Petr, C., & Spano, R. (1990). Evolution of social services for children with emotional disorders. *Social Work, 35,* 228-234.

Poertner, J. (1990). Why we need a local children's authority. In *Rethinking children's services in Kansas, Conference papers* (pp. 1-9). Lawrence, KS: The University of Kansas.

Rapp, C., & Poertner, J. (in press). *Client centered social administration.* New York: Longman.

Robison, S. D. (1990). *Putting the pieces together: Survey of state systems for children in crisis.* Denver: National Conference of State Legislatures.

Saxe, L., Cross, T., & Silverman, N. (1988). Children's mental health: The gap between what we know and what we do. *American Psychologist, 43,* 800-807.

Saxe, L., & Dougherty, D. (1986). *Children's mental health needs: Problems and services.* Washington, DC: Office of Technology Assistance, U.S. Government Printing Office.

Scheirer, M. A. (1981). *Program implementation: The organizational context.* Beverly Hills: Sage Publications.

Scheirer, M. A., & Rezmovic, E. L. (1983). Measuring the degree of program evaluation: A methodological review. *Evaluation Review, 7*(5), 601.

Spano, R. (1986). Creating the context for the analysis of social policies: Understanding the historical context. In D. Chambers (Ed.), *Social policy and social administration: A method for the practical public policy analyst* (pp. 38-53). New York: Macmillan.

Stroul, B., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth.* Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Stroul, B., & Goldman, S. (1990). Study of community-based services for children and adolescents who are severely emotionally disturbed. *Journal of Mental Health Administration, 17*(1), 61-77.

Weithorn, L. A. (1988). Mental hospitalization of troublesome youth: An analysis of skyrocketing admission rates. *Stanford Law Review, 40*, 773-837.

APPENDIX A
Documents Reviewed

State Level Documents

"Department of Human Services Organizational Chart"

"Minnesota Comprehensive Children's Mental Health Act" (MNS 245.487-4887).

"Overview: Minnesota Comprehensive Children's Mental Health Act"

"1990 Mental Health Report to the Legislature, 2/90"

"Duty to Ensure Placement Prevention and Family Reunification
MN stat. 260.012" (Reasonable Efforts)

"Substitute and Adoptive Care--Annual State Report, 1987"

"Children's Community Mental Health Act of 1989: Eligibility Groups"

"Children's Community Mental Health Act of 1989: Mental Health Practitioners"

"Children's Community Mental Health Act of 1989: Mental Health Professionals"

"Children's Community Mental Health Act of 1989: Local Advisory Councils"

"Children's Community Mental Health Act of 1989: Local Coordinating Councils"

Hennepin County Documents

"Community Services Department Organization Chart"

"Geographical Distribution Report--1989"

"Home-Based Services Follow-Up Study" (6/87)

"Effectiveness of Intensive Home-Based Services"

"1990-91 Community Social Services Plan" (Vol I, Vol II, and Appendices)

"Recommendations Regarding Purchased Services for Handicapped Children"

"Early Childhood Services Case Referral and Decision Process"

"Home Community Treatment (HCT)--Home Team Services"

"Early Childhood Services"

"Early Childhood Services Unit"

"Social Services Available"

"Social Services Provided"

"Placement Consultation Format"

"Equal Access & Privacy Rights"

Staff Development Catalogue--Fall 1989

Staff Development Catalogue--Winter 1990

Staff Development Catalogue--Spring 1990

APPENDIX B
Interview Questions

1. In general, what impact does a child with a disability have on a family?

2. With reference to permanency planning and "reasonable efforts" to maintain family unity when the child involved has a disability, what does Minnesota do better than other states? What does Hennipen County do better than other counties? What do other states do better than you do in Minnesota? What do other counties do better than Hennipen County?

3. What are the barriers to implementing policies and programs regarding reasonable efforts with families who have a child with an emotional disability, with a developmental disability, who is medically fragile?
4. What are the "reasonable efforts" that are usually made with a family having a child with a disability? Are they the same or different for children without disabilities?

5. Which of these efforts are most appropriate for families of kids with emotional disability? With developmental disability? With kids who are medically fragile? Are they the same or different for children without this disability?

6. How do you determine which efforts are best made prior to out-of-home placement, to prevent placement; and which are best suited to reunification efforts? Are the same efforts made before *and* after placement? Regarding efforts that are made before out-of-home placement and those that are made after placement, are the same services available for biological parents and foster parents?

7. Are records maintained regarding which services are used most often by particular disability populations?

8. In drawing up a child's service plan prior to placement, what part are parents and other family members expected to play? What part are they expected to play after placement? What do they do that is perceived as helpful and what is perceived as interference or negative in some way? Are expectations for family participation the same or different for families with a child having a disability?

9. Is there a "Parents' Handbook" to explain policies and services to parents? If so, who is responsible for developing it? Is there a formal review process to ensure that it continues to be accurate? Is the same handbook used for parents whose child has a disability?

10. Is there a procedure for verifying the accuracy of a finding that a child is "at risk" or in need of out-of-home placement? Are there specific forms used to document an "at-risk" finding or the need for out-of-home placement? Are line workers required, in each case, to demonstrate the effectiveness and/or adequacy of a service plan for a given child or family?
If not, how is the adequacy of a service plan evaluated? Is this the same or different for children with a disability?

11. Whose task is it to review policies regarding services? Is there a formal review process to assess the adequacy of programs and services? If so, how often is the review done?

12. What are the main features of training for line workers who work with children with disabilities and their families? Is the training different for those not working with children with a disability?

13. What are the criteria used to determine whether line workers and supervisors are working effectively in cases involving a disability? Is this the same as or different from expectations when a disability is not involved?

14. Does this agency have the flexibility to shift funds from out-of-home placement to "preventive and reunification services"?

15. When resources are scarce, is all the money that is allocated for programs and services actually spent? Who decides whether to expend all allocated funds? Who decides the level of funding for particular programs and services and how are these decisions made?

16. Who decides how much funding will be used on "reasonable efforts" services and where the funding will come from? Who makes this decision regarding services to children with emotional disability? With developmental disability? With kids who are medically fragile?

17. How much money is currently earmarked for "reasonable efforts" for children who have developmental disabilities; for children with emotional disabilities; for medically fragile children?

18. What impact do judges have on the provision of services to children with disabilities?

19. What role do advocacy groups play in influencing the implementation of policies and programs pertaining to children with disabilities?

20. How do federal laws help and hinder permanency planning efforts with kids who have a disability?

APPENDIX C
Persons Interviewed

NAME	POSITION	DATE	LENGTH OF INTERVIEW
<u>State Level</u>			
Erin Sullivan-Sutton	Acting Director--Children's Services, Dept. Human Services	6/6/90	2 hours
Jerry Sudderth	Director--Mental Health Division, DHS	10/90	1 hour (phone)
Joan Sykora	Mental Health Program Consultant Child & Adolescent Services, DHS	6/6/90	6 hours (5 hrs/phone)
Jerry Lindskog	Family-Based Services Consultant, Children's Services, DHS	6/6/90	2 hours
<u>County Level</u>:			
Mike Webber	Director--Community Services Department Hennepin County, MN	4/18/90 4/20/90	1 hour 1 hour
Carol Ogren	Manager--Family Services Division, CDS	4/19/90 11/90	1.5 hours .5 hour (phone)
David Sanders	Project coordinator--Children's Mental Health Project, CSD	4/19/90 1/9/91	1.5 hours 1 hour (phone)
Carol Miller	Supervisor--Early Services Unit, CSD	4/19/90	1.5 hours
Phil Auclaire	Supervisor--Management Information Services Unit, Management/Planning Div.	4/19/90	1 hour
Gwen McMahon	Sr. Social Worker--Family Services Div.	4/19/90 4/20/90 11/90	1.5 hours 1 hour 1 hour (phone)
Rex Holzmer	Sr. Social Worker--Child Welfare Div.	4/20/90	1 hour
Dixie Jordan	Parent/Advocate for PACER	6/6/90	1 hour

		11/11/90	2 hours
Louise Brown	Advocate	1/9/91	2 hours
Ron Brand	Exec. Dir., MN Assoc. of Community Mental Health Programs	1/17/91	1.5 hours
Susan Karstens	Police Dept. Psychologist & Spokesperson for Minnesotans for Improved Juvenile Justice	1/17/91	.5 hour
Catherine Mayer, M.D.	Psychiatrist, Consultant to County Mental Health Center	1/18/91	.5 hour (phone)
		2/13/91	.5 hour (phone)

Beach Center on Families and Disability

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